QUALITY, AFFORDABLE, HEALTH CARE FOR ALL

ReformsKool: What's Hot in HCR

Issue 18
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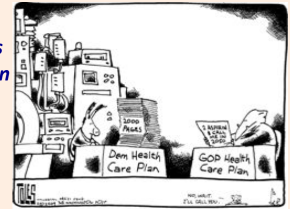
The Weekly Digest of the Health Care for All Campaign of the American Medical Student Association

The Capitol Beat: Recapping This Week's Action

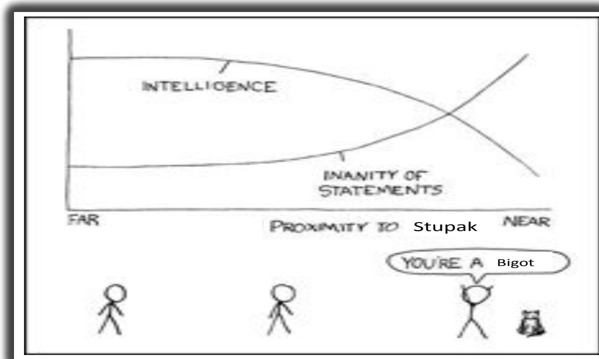


Not feeling up to speed with theory, definitions, or AMSA's policies? As always at ReformsKool, we want to get everyone familiar with the language, concepts, and current status of the health care reform (HCR) process. AMSA is fighting hard to ensure that the legislation currently in Congress includes a strong and robust public insurance option at a minimum. For more details on AMSA's stance on health care reform and definitions, see page 3.

Senate, Senate, Senate. Late Wednesday evening, the vast majority of Democratic leadership finally came to a consensus around a merged Senate health reform bill – S 3590 – *The Patient Protection and Affordable Care Act of 2009*. This coincided with the announcement of the Congressional Budget Office score of the Senate language – the verdict? A cool $849 billion over ten years to insure an additional 31 million Americans – a far cry from the coverage offered by a Medicare-for-all, or even a public-option-open- to-all plan - one which would cost markedly less. Like the House bill, Sen. Harry Reid's (D-NV) legislation includes an individual mandate with minimal exceptions. As in the House, the Senate's public option, in its current form, would be forced to negotiate provider rates and permit individual states to opt-out – a dangerous precedent that undermines an already weak public plan. Regarding abortion, S 3590 incorporates current Hyde amendment restrictions on use of federal funds for abortion, but the public option and private plans in the Exchange may segregate federal subsidies and use only co-pays and consumer premium contributions to pay for abortions, restricting access to an as-yet unknown extent. With regard to coverage of undocumented immigrants, the Senate has set a new precedent of dis-inclusion. While the HR 3962 does not allow federal subsidies to be provided to this population, the Senate prohibits them from purchasing insurance from the Exchange – even if they are able to pay the full cost out-of-pocket. In order to pay for S 3590, the Senate will impose new taxes and fees, including a 40 percent excise tax on 'Cadillac health plans' (will raise $149 billion by 2019), a five percent tax on elective cosmetic medical procedures paid by patients, cuts to Medicare and Medicare Advantage, and annual fees – allocated by market share – on health care companies (medical device, insurance, and pharmaceutical). Sen. Reid has now filed cloture on S 3590, with a procedural vote – a motion to proceed – expected as early as Saturday evening. Currently three Democrats – Ben Nelson (NE), Blanche Lincoln (AK), and Mary Landrieu (LA) – and independent Joe Lieberman (CT) are posturing against the bill. Sen. Lieberman has said that he won't vote against cloture to begin the debate, but he will filibuster a public option. Denise Dennis of the Huffington Post asks a timely question: "Instead of dancing to the tune of the avaricious insurance lobby, Lieberman, Nelson and company should put themselves in the shoes of the uninsured Americans they were elected to serve. How can they put a price on providing available health care? How can they put a price on saving lives? How can they put greed and personal ambition above human decency?" And late-breaking news, in keeping with promises made to the AMA, the sustainable growth rate fix in the House (HR3961) passed 243-183 – we'll see if it makes it through Conference – more to come soon!

Iyah Romm, Liz Wiley, JD, MPH, and Sylvia Thompson, MD

What is YOUR Stupak-ness?



Seacouver!!

Interested in the current state of healthcare in the US? Want to gain hands-on experience while comparing two different health care systems?

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Questions? Contact Jessie Whitfield (jwhitfi6@slu.edu)

Authors/Editors/Dancers Needed!!

Submission Guidelines:

- **Submissions should address a current domestic or global health care reform issue.**
- **Submissions may be up to 500 words.**
- **E-Mail submissions to brd.1@amsa.org.**

Not a writer but want to be involved? What skills do you have? Come be an editor! Help with layout! Gather videos or create your own multimedia tools! We're ALWAYS looking for creative folks to help improve AMSA's newest and most exciting publication!

In the News…

- *"Monopoly on Expensive, Life-Saving Drugs Unfair" – AJC, 11/17/09*
- *"Reid Considers Raising Medicare Tax for High Earners" – LA Times, 11/17/09*
- *"How to Pass a Health Bill Fast" – Politico, 11/18/09*
- *"Reid Announces Saturday Test Vote" – Politico, 11/19/09*
- *"The Ersatz Public Option" – HuffPost, 11/19/09*
- *"From Clinics to Coathangers: Stupak-Pitts is an Affront to Women, Democracy, and Civil Rights" – FDL 11/17/09*

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TAKE ACTION - Abort Stupak-Pitts

Sign this petition and send a coat hanger to the 20 formerly pro-choice Democrats -- all men -- who voted to pass the Stupak Amendment.

We know what happens when women are denied access to reproductive health care including abortion. And we can't go back to an era of coat hangers and back alley abortions. Reconsider your vote on the Stupak amendment. Tell House Speaker Nancy Pelosi and Senate Majority Leader Harry Reid that the final health care bill that emerges from the conference committee can't turn the clock back on women's rights.

Pro-Reform Activists Rally in Chicago
10/23/09

'Preggers Can't Be Choosers'
The Daily Show
11/12/09

Bundling Away Fee-For-Service

As the current health care reform debate rages on, many advocate a shift away from the predominant compensation scheme, fee-for-service (FFS). In this model, providers are remunerated for individual visits or procedures. For example, following a visit to the family physician for an annual physical, the patient or insurance company is billed separately for the physician's time, diagnostic testing, and any lab work. While this model ensures that providers are paid for their services, it has many significant failings.

The FFS model's emphasis on quantity over quality has been blamed for many of the health care system's ills. It rewards those who order more diagnostic studies or perform more procedures irrespective of benefit to the patient. Outcome and quality are disconnected from the reimbursement schema, and there are no incentives to provide counseling or prevention services. Redundant testing is the norm and there is inadequate care coordination among providers.

Touted by influential leaders, from President Obama to health care CEO's, the leading alternative to FFS is bundled payments. Here, providers are paid a lump sum for all services rendered in a single episode of care - a patient with diabetes, for example, may see multiple providers including dieticians, endocrinologists, ophthalmologists, podiatrists, and primary care physicians. By collaborating to keep the patient from developing complications and preventing hospitalizations, the providers are able to earn a larger share of this lump sum. They have no incentive to order tests or treatments that are not beneficial because these subtract from their income. Yet, if the team does not meet various quality benchmarks or the patient's health does not improve, they also earn less. Importantly, providers are not penalized for the occurrence of conditions that are out of their control and payments are adjusted by the severity of the patient's illness.

This payment plan is distinct from capitation, in which providers also receive a fixed amount to care for the patient. While there is significant incentive to restrict care in a capitation model, there is no remuneration for quality improvement. Furthermore, there is no adjustment under capitation based on illness severity.

According to a recent article published in the New England Journal of Medicine,[1] of all potential schemes to reduce health care spending in United States, bundled payments have the most potential for savings, by far. Authors Hussey *et al* assert that under a specific bundle payment plan, called Prometheus, changes in national health care spending could decrease by up to 5.4%.

There are, however, some disadvantages to bundled payments. Principally, it is difficult to coordinate care among multiple entities. This is particularly evident in rural settings or single provider practices. Also, if the bundle includes hospitalization care, as in the case of a hip replacement, for example, the funds may flow through the hospital. As a result, physicians may be forced to constantly negotiate with the hospital for reimbursements.

While a bundled payment model is not new, it does seem to be the wave of the future. There are multiple demonstrations occurring throughout the country, and the House health reform bill provides funding for more extensive pilot projects.

*~ **David Rand**, MS4 at Philadelphia College of Osteopathic Medicine, is a new ReformsKool columnist!*

1. Hussey P,Eibner C, Ridgely M, McGlynn E. Controlling U.S. Health Care Spending — Separating Promising from Unpromising Approaches. Published at www.nejm.org November 11, 2009

STAT

Want to let your legislators know how you feel about health care reform but don't have much time? Join STAT! STAT is a rapid response team of medical students. Members commit to 1-2 quick actions, taking 5-10 minutes, each month. To join, go to http://groups.google.com/group/stat2009/

Contact Congress Directly!

HOST a PNHP SPEAKER at YOUR SCHOOL!

Physicians for a National Health Program (PNHP) has speakers around the country ready to provide exciting lunchtime presentations (and FREE lunch!). To request a speaker, email Dave at dave@pnhp.org!

All contributions are the work of the authors, and do not necessarily reflect the views or opinions of the American Medical Student Association. Please contact the authors, **Sylvia Thompson, MD** (policy.chair@amsa.org), **Iyah Romm** (brd.1@amsa.org), or **Liz Wiley, JD, MPH** (studentlife.policy@amsa.org) with any questions, comments, or concerns.

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QUALITY, AFFORDABLE, HEALTH CARE FOR ALL

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A Brief Overview of HCR

In 1993 the Clinton Administration attempted to pass comprehensive health care reform legislation. These efforts were quickly derailed due to strong opposition from Congress, who bristled at the top-down mandates favored by the White House. President Obama is attempting to circumnavigate these hurdles by allowing Congress to draft HCR legislation. Two different bills will eventually be created, one in the House of Representatives, and one in the Senate. These bills will then be reconciled and sent to the White House for President Obama to sign or veto.

•**House:** There are three committees in the House responsible for working on HCR. They have jointly written one bill, HR 3200. The "Tri-Committees" are Energy and Commerce, Ways and Means, and Education and Labor.

•**Senate:** There are two committees in the Senate working on HCR. The Health, Education, Labor, and Pensions (HELP) committee, which released a bill on June 9. The Finance Committee (FinCom) has not yet made their legislative language available to the public.

Single Payer, Public Options, and Co-Ops

Single Payer: A publically funded, privately delivered program like Medicare. Physicians and hospitals are independent entities, reimbursed by the government. This is NOT socialized medicine, where both the funding and the delivery are public (i.e. doctors are government employees). The Congressional Budget Office (CBO) has stated that a Single Payer health care system would save the U.S. $3.5 trillion over 10 years.

Public Option: This maintains the current health insurance system, but adds a publically funded, privately delivered option. There are many forms that a public option can take. In the most robust of systems, all Americans are able to buy-in at sliding-scale rates that they can afford. In weaker public option proposals, specific criteria restrict eligibility to only a small portion of the population.

Co-ops: A group insurance plan composed of many not-for-profit entities (individuals or organizations) who act as self-insurers – collecting premiums in order to create a large risk pool to drive down costs. Co-ops would dictate premium and coverage variation state-by-state (50 co-ops in total would exist). The federal government would provide seed money for initial costs and capitalization. There has also been peripheral discussion of a national co-op.

AMSA's Stance on Health Care Reform

The American Medical Student Association believes that the best solution to our health care crisis is a single-payer system of publicly funded, publicly accountable, privately provided, Quality, Affordable, Health Care For All. In the current legislative environment, however, we consider the following to be **essential** to health care reform that has the potential to effectively contain costs, improve quality, and ensure access for all:

- Establishing a single, federally administered public insurance option, providing uniform benefits across the US, enacted concurrently with other provisions of health care reform and available to individuals and employers widely. The public plan must be allowed to set premiums and payment structure in negotiations with stakeholders, independent of other insurance plans, but subject to all federal insurance requirements.

- Requiring all insurers, public and private, to (1) guarantee issue of insurance to all; (2) set premiums by community rating, without regard to health status; (3) offer comprehensive benefits packages that meet a common actuarial standard; and (4) not institute annual or lifetime caps on benefits.

Further, AMSA actively advocates for:

- Establishing a public insurance option that further (1) makes use of the existing administrative infrastructure of Medicare to maximize operational efficiency; (2) receives a level of subsidy that is no less than that received by private plans.

- Structuring of provider payment to improve quality and promote prevention, primary care, the medical home, chronic care management, and public health.

- Subsidies to make purchase of insurance truly affordable and reasonable limits on out-of-pocket expenses to protect individuals and families from the catastrophic financial effects of serious illness.

- A standardized and defined benefit to apply to all insurance plans, which covers comprehensive services related to prevention, mental health, maternal and child health (including reproductive health), long-term care, vision, and dental care, as well as prescription drug coverage.

- Standards for transparently outlining benefits that will enable individuals to choose between plans based on objective information.

- Requirements that insurers take positive steps to decrease health care disparities based on region, income, minority status, gender and disability.

Well, I'm a, you know, doctor; I'm not a politician. I feel a little bit like we're debating whether to give aspirin or Tylenol to a patient with breast cancer. The patient needs surgery. And what's being debated in Washington is really Tylenol or aspirin. And I had said for awhile we'd have to see the final shape of the bill, because, of course, we'd-I'd love to see more Medicaid money. Medicaid is very helpful for very poor people. It's not perfect, but it's much better than nothing. But I think there's so many bad planks in the bill that this bill needs to be scratched, and we need to start over.

~ Dr. Steffie Woolhandler